(SER). Patients were randomized to choice arm (n = 97) and no-choice arm (n = 103). In the choice arm, patients chose their preferred treatment either PE (n = 61) or SER (n = 36). While in the no-choice arm, patients were randomly assigned to either PE (n = 48) or SER (n = 55). Health utility was measured using the EQ-5D instrument at baseline and 10-week post-treatment. The EQ-5D index scores were generated using the U.S. general population-based models: D1 and MM-OC. Health utilities associated with treatments, treatment choices, and treatment response were estimated using multivariate regression. **RESULTS:** At baseline, mean EQ-5D utility scores (SD) associated with currently diagnosed PTSD were 0.630 (0.191) and 0.682 (0.239) using D1 and MM-OC models, respectively. At post-treatment, mean difference in EQ-5D scores between PE and SER using D1 and MM-OC models were 0.144 ($p < 0.001$) and 0.180 ($p < 0.001$), respectively. Mean difference in EQ-5D scores between giving choices of treatment and assigning to treatment were 0.064 ($p = 0.08$) and 0.089 ($p < 0.05$) for D1 and MM-OC models, respectively. For treatment response, mean difference in EQ-5D scores between responders and non-responders using D1 and MM-OC models were 0.255 ($p < 0.001$) and 0.295 ($p < 0.001$), respectively. **CONCLUSIONS:** Psychotherapy, giving patients an opportunity to choose their treatment, and response to therapy are associated with increased health utilities. Health utility estimates from the current study can be applied to conduct cost-effectiveness analyses.

PHS57

HEALTH-RELATED QUALITY OF LIFE (HRQOL) IN COLORECTAL CANCER PATIENTS WHO FINISH THEIR TREATMENT IN A TERTIARY HOSPITAL

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OBJECTIVES: To determine the HRQoL scores in colorectal patients treated with a curative intent as outpatients after having completed their treatment in a tertiary hospital. **METHODS:** We selected patients with colorectal cancer, treated with a curative intent. At the end of the treatment we applied the EORTC questionnaires: QLQ-C30, QLQ-CR29 and IN-PATSAT32. The mean and standard deviation were calculated. The scores for questionnaires were calculated with formulas and instructions according to EORTC Scoring Manual. The scores were correlated through Pearson¨R test. **RESULTS:** Global health status/QoL showed a mean score of 88.26 (±16.99); the other means were: role functioning 97.73 (±7.79), emotional functioning 84.09 (±13.34), diarrhoea 15.15 (±26.68), constipation 13.64 (±19.68), urinary frequency 22.73 (±29.34), abdominal pain 7.58 (±14.30), bloating 7.58 (±14.30), dry mouth 9.09 (±18.35), sore skin 15.15 (±32.08), stoma care problems 16.67 (±25.20). In the satisfaction questionnaire, the scores for doctors showed: technical skills 90.15 (±15.14) and information provision 90.91 (±16.65), for nurses: technical skills 76.89 (±24.25) and information provision 68.94 (±25.22), access 58.52 (±23.90), waiting times 54.55 (±26.32), comfort/cleanness 61.36 (±31.55) and general satisfaction 72.73 (±25.48). We also documented associations between physical functioning and body surface (rP 0.52; p 0.01), role functioning and carcinoembryonic antigen (rP-0.45; p0.03), cognitive functioning and glucose serum levels (rP-0.51; p 0.01), pain and peripheral blood leucocyte count (rP 0.73; p 0.000), sexual interest (men) and albumin serum levels (rP 0.85; p 0.01), dry mouth and glucose serum levels (rP 0.55; p 0.008) and between flatulence and glucose serum levels (rP 0.47; p 0.026). **CONCLUSIONS:** Emotional functioning and psychological issues are not systematically treated at our institucion. Satisfaction with doctors was better than with nurse personnel. Malnutrition impacts negatively both in role and sexual functioning in the colorectal cancer patients.

PHS58

DESIGNING A PATIENT PREFERENCES SURVEY ON SPECIALIST REFERRAL FOR TOTAL JOINT REPLACEMENT PATIENT CHOICE WITH ALTERNATIVE SPECIFICATIONS OF THE STATUS-QUO

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OBJECTIVES: Long waiting times for hip and knee total joint replacement (TJR) are a major concern in health care systems with universal health care coverage. Giving patients the option of choosing the next available surgeon, as opposed to waiting for a specific surgeon, may improve access to care. We measured patient preferences about referral choices and waiting times using a discrete choice experiment (DCE) survey. **METHODS:** The attributes and levels informing DCE choice tasks were derived through a literature review, clinical and policy experts, and seven focus groups in four Canadian centers. 176 consecutive patients referred to an orthopaedic surgeon for TJR at two sites completed the survey of 14 choice tasks, each with 5 attributes (reputation, process of referral from primary care to specialist, waiting time to consult, waiting time to surgery, travel time to hospital) and 3 to 6 attribute levels. We tested different specifications for the surgeon reputation attribute and two alternative specifications of status quo/opt-out to inform the full study. We estimated preferences using conditional logit regression. **RESULTS:** Poor surgeon reputation dominated in one of four survey versions. Using the remaining respondents (n=135), surgeon reputation was the most important attribute in each version. 'Not knowing' the surgeon reputation was as important as an 'excellent' reputation. The waiting time to surgery was the next most important attribute, and was more important than waiting time to consult and the remaining attributes. There was no statistically significant difference between 'waiting for a specific surgeon' or the 'next available surgeon'. Preferences in alternative specifications of status quo/opt-out were statistically different. **CONCLUSIONS:** The surgeon reputation is a key element of surgeon selection, and patients are willing to choose the next available surgeon in order to reduce waiting times providing that they know the surgeon has at least a satisfactory reputation.

PHS59

PREFERENCES OF APPALACHIAN WOMEN FOR INTERVENTIONS STRATEGIES IN A MOBILE MAMMOGRAPHY PROGRAM

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OBJECTIVES: Rural Appalachian women are significantly more likely to never having had an age appropriate mammogram. The objectives of the study were to determine the information sources about mammography screening used by West Virginia women age 40 years and above, who have had their first mammogram at a mobile mammography unit. The types of targeted educational interventions accompanying the mobile mammography unit perceived as likely to be acceptable and effective with never screened women were also determined. **METHODS:** A qualitative study using structured telephone interviews of 16 women age 40 years and above who have had their first mammogram at a mobile mammography unit were conducted with a structured questionnaire. Participants received $25 gift card for their time and participation. Transcripts were coded by two researchers to reduce bias. Thematic analysis of data was conducted to identify themes and sub-themes from the data collected. **RESULTS:** The information sources used by rural women included doctors (81.25%), materials from library (43.75%), health fairs (37.50%), internet (37.50%), local health center (25.0%), nurses (18.75%), hospital (6.25%) and senior centers (6.25%). Fifty-six percent of women specified using social media such as Facebook, and Linked-in to get information about mammography screening. Community-based health educational programs that could be held at public places such as a local library or church or work-sites and mailed educational material about mammography screening and its importance were perceived to be the most helpful interventions that could be developed around a mobile mammography program. **CONCLUSIONS:** The results of the study indicate the important role of health care providers in influencing women to get mammography screening. Community-based education programs and mailed education materials are likely to be the most effective interventions to increase first time mammography screening via a mobile mammography unit.

PHS60

ASSOCIATION BETWEEN COMORBID OBESITY WITH HEALTH STATUS, DISABILITY AND HEALTH-RELATED QUALITY OF LIFE IN A NATIONALLY REPRESENTATIVE TYPE 2 DIABETES MELLITUS POPULATION

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OBJECTIVES: To examine patterns of health status, disability, and health-related quality of life in type 2 diabetes mellitus (T2DM) patients by comorbid obesity using a nationally representative US sample. **METHODS:** The 2009 Medical Expenditure Panel Survey was analyzed to identify adults (≥20 years) with diabetes (ICD-9-CM: 250). T2DM was identified if one of the following criteria was met: 1) evidence of ≥1 oral or non-insulin injectable anti-diabetic medication; 2) diagnosis of diabetes after age 30; 3) diagnosis before age 30 and not on insulin monotherapy. Self-perceived health status, limitation in activities of daily living (ADL)/instrumental ADL (IADL), and physical/mental component summary scores from the SF-12 were examined and compared by the presence of obesity (BMI≥30 kg/m^2). Linear and logistic regressions were performed to assess the association between obesity and these outcomes. Nationally representative estimates were produced by applying population weights accounting for the multi-stage sampling design. **RESULTS:** This study included 2,269 respondents with T2DM (representing 19.2 million T2DM patients in the US), 54.5% of whom were obese. Compared to non-obese T2DM patients, obese diabetics had a higher proportion of self-perceived fair/poor health (41.9% vs. 34.5%, $p<0.01$) and limitations in IADL (12.1% vs. 8.7%, $p=0.03$), and a lower SF-12 physical score (38.4 vs. 42.3, $p<0.01$) while limitations in ADL and SF-12 mental score were similar. After adjusting for age, gender, race, income, insured status, and comorbidities, obese T2DM patients were more likely to have limitations in IADL (OR=1.89, 95% CI:1.28-2.78) and scored 4.3 points lower on the SF-12 physical component ($p<0.01$) than non-obese patients, while no significant differences were found in reporting fair/poor health, limitations in ADL, and SF-12 mental score. **CONCLUSIONS:** T2DM patients with comorbid obesity had greater disability in IADL and worse physical health-related quality of life. The deleterious impact of obesity should be considered when managing T2DM patients.

PHS61

IMPACT OF SPORTS ON CHILDREN WITH HAEMOPHILIA IN TERMS OF THEIR HEALTH STATUS, HEALTH-RELATED QUALITY OF LIFE AND PHYSICAL PERFORMANCE

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Haemophilia, a congenital bleeding disorder with recurrent bleeding in joints and muscles, leads to arthropathy and disability. Sport is considered beneficial for children with haemophilia in terms of physical health, motor coordination and psychological equilibrium, which might reduce bleeding frequency. **OBJECTIVES:** To evaluate the impact of sport on health status, health-related quality of life (HRQoL) and physical performance in haemophilic children.